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Supreme Court, U.S.
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No. 95-2000

In The

Supreme Court of the United States

October Term, 1995

SCOTT D. LEVINE, M.D.,

Petitioner,

vs.

CENTRAL FLORIDA MEDICAL AFFILIATES, INC.; HEALTHCHOICE, INC.; SAND LAKE HOSPITAL; ORLANDO REGIONAL HEALTHCARE SYSTEM, INC., f/k/a ORLANDO REGIONAL MEDICAL CENTER,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF OF RESPONDENTS HEALTHCHOICE, INC. AND ORLANDO REGIONAL HEALTHCARE SYSTEM, INC. IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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LIST OF PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES

Pursuant to Supreme Court Rule 29(6), the following constitutes a list of all parent companies and nonwholly owned subsidiaries of Orlando Regional Healthcare System, Inc. and Healthchoice, Inc.:

1. Healthnet Services, Inc. is the parent company of Healthchoice, Inc. and a wholly-owned subsidiary of Orlando Regional Healthcare System, Inc. ("ORHS").

2. ORHS is a 50% owner of M.D. Anderson Cancer Center of Orlando, Inc.

3. ORHS is a 50% owner of South Lake Hospital, Inc.

4. ORHS is a limited partner in Orlando Institute for Cardiac Care, Ltd., d/b/a Outpatient Cardiovascular Center of Orlando.

5. ORHS has numerous other wholly owned subsidiaries.

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STATUTE

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I.

STATEMENT OF THE CASE

This is a case about one highly successful physician, Petitioner Scott D. Levine, who was denied membership in one managed health care plan with a market share of less than 6%, and whose medical staff privileges were temporarily suspended by a non-profit hospital system with 29% of the hospital beds in the Orlando, Florida area. It is a case in which the plaintiff physician was highly successful prior to the events giving rise to this litigation, and even more successful following the actions alleged by the plaintiff physician to constitute antitrust violations. It is not a case about injury to competition. It is not a case brought by the government to challenge the validity of a managed care plan, nor is it a challenge to a managed care plan by a purchaser of managed care. It is an attempt by a single competitor to create a federal antitrust suit for the purposes of recovering treble damages. The U.S. District Court for the Middle District of Florida, and the Eleventh Circuit Court of Appeals, in a well reasoned opinion, both soundly rejected the Petitioner's antitrust claims. For the reasons set forth below, these Respondents respectfully submit that the Petitioner's Petition for Writ of Certiorari should be denied.

Orlando Regional Healthcare System, Inc. f/k/a Orlando Regional Medical Center ("ORHS") is a not for profit corporation which operates a hospital network in the metropolitan Orlando area. Healthchoice, Inc. ("Healthchoice") operates a preferred provider organization ("PPO") in the same area and is owned by Healthnet Services, Inc., a wholly owned for-profit subsidiary of

ORHS. Dr. Levine filed the antitrust claims in question against ORHS, Sand Lake Hospital (a division of ORHS), Healthchoice, and Central Florida Medical Affiliates, Inc. ("CFMA").

Part of Petitioner's claim relates to an administrative decision made by Healthchoice staff to deny Dr Levine's request for membership in the Healthchoice Preferred Provider Organization. The decision was made based on the fact that there were already an adequate number of internal medicine physicians practicing in Dr. Levine's geographical area. Later, in an unrelated action, Dr. Levine's medical staff privileges were temporarily suspended by ORHS because of concerns regarding the quality of his patient care. Dr. Levine also asserted an antitrust claim against ORHS relating to that temporary suspension.

Following the grant of summary judgment in favor of Respondents on Petitioner's antitrust claims, Petitioner appealed to the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the District Court's order granting summary judgment (see *Levine v. Central Florida Medical Affiliates, Inc. et al.*, 72 F.3d 1538 (11th Cir. 1996)) and Petitioner seeks review of that Order.

Dr. Levine, in his Statement of the Case, omitted several relevant facts from his Petition. Specifically, the following uncontroverted facts were presented to the U.S. District Court and the Eleventh Circuit Court of Appeals:

1. Dr. Levine has enjoyed great financial success in the practice of medicine. Dr. Levine's pre-tax net earnings from the practice of

medicine from 1990 through 1992 is summarized in the following table:

1990	$553,176.00
1991	$724,722.00
1992	$692,079.00

In the year during which Dr. Levine alleges that he was the victim of an antitrust conspiracy (1991), he actually increased his income by thirty-one percent ($171,546.00) over the preceding year. (R2-53-466-485). According to the Center for Health Policy Research of the American Medical Association, the average pre-tax net earnings for self-employed Florida internists in 1991 was $191,200.00, and the 75th percentile pre-tax net earnings for Florida internists in 1991 was $240,000.00. (R2-49-¶ 37).

2. During the relevant time period, Dr. Levine was one of approximately 2,200 licensed physicians practicing in the Orlando Area. Records of managed care plans in the Orlando Area indicated that over 400 Orlando Area internists participate in managed care plans. (R2-49-¶ 15; R3-80-¶ 16). At the time that Dr. Levine's privileges were temporarily suspended by ORHS in 1991 there were 163 members of the Department of Medicine at ORHS, and there were 236 such members as of 1994. (R3-65-¶ 2).

3. The market for health care insurance in the Orlando Area is highly competitive. In 1994, there were at least 38 PPOs and 11 Health Maintenance Organizations ("HMOs") operating in the Orlando Area, and a vast array

of traditional comprehensive insurance coverage ("TCIC") companies. (R3-80, Exh.A.) TCIC's pay health care providers on a fee-for-service basis. Payors in PPOs and in some HMOs also pay providers on a fee-for-service basis. However, such fees are negotiated in advance, at a discounted rate. Providers are compensated for their discounted rate because the PPO and/or HMO provides them with an increased patient base. HMOs generally restrict their enrollees solely to use of Network providers. PPOs do not prohibit enrollees from utilizing non-Network providers; however, economic incentives are usually provided to the enrollee if Network providers are used. (R3-80-¶ 4.)

4. Market studies prepared by Healthchoice indicated that of an Orlando Area population of approximately 1,137,000, 69% were covered under HMO or PPO plans, with the remainder having TCIC or no coverage at all. No single PPO or HMO covered more than 7.5% of the population. In 1994, Healthchoice had approximately 68,000 enrollees, representing less than 6% of the Orlando health care market.

5. At the time in question, Healthchoice had 863 physicians in its Network in Orange, Seminole, and Osceola Counties, eighty (80) of whom indicated their specialty area as internal medicine, the area in which Dr. Levine practices. There were approximately 2,200 licensed physicians in the Orlando Area, and over 400 internists in the Orlando Area participate in managed care plans. (R3-49-¶ 15; R3-80-¶ 16.) There were twenty-one (21) hospitals in the

Orlando Area, nine (9) of which were in the Healthchoice Network. Four (4) of those hospitals had no affiliation with ORHS, including Health Central and Winter Park Hospital, two of ORHS's significant competitors. (R3-80-¶ 22.)

6. CFMA is a for-profit corporation. It is not necessary to be a member of CFMA to be a participating physician in the Healthchoice Network, and numerous physician members of Healthchoice are not members of CFMA. CFMA primarily acts as a physician advocacy group. (R3-80-¶ 10.) Initially, CFMA was responsible for credentialing physicians for membership in Healthchoice; i.e. determining their competency as physicians. This is a separate and distinct issue from determining the need for additional physicians in the Network. Healthchoice was always responsible for determining the need for additional physicians in the Network. Since 1991, Healthchoice has also taken over responsibility for credentialing decisions. (R3-80-¶ 10.)

7. The hospital services market in the Orlando Area, defined as Orange, Seminole, and Osceola Counties, has approximately 4,446 licensed hospital beds. The hospital market in the Orlando Area has three major competitors, ORHS, Florida Hospital, and Columbia Park Healthcare, along with a number of smaller hospitals. At all times relevant to this action, the largest of these competitors was Florida Hospital, which had 33% of the licensed beds in the Orlando Area. ORHS had 29% of the licensed beds. (R2-49-¶ 20 Exh. "I"; R3-68-¶ 3).

8. Dr. Levine's ability to compete in the internal medicine market in Orlando was never affected by any of the Respondents' actions in this matter. He held medical staff privileges at Florida Hospital's several campuses, Health Central, Charter Hospital, and Glenbeigh Hospital throughout the ORHS disciplinary process. (R2-52-126, 138). Thus, even during his temporary suspension at ORHS, Dr. Levine had access to several other hospitals with 1,623 licensed beds. Accordingly, Dr. Levine, and his patients, could access 37% of the licensed hospital beds in the Orlando Area even during the period of his temporary suspension. (R2-49-¶ 20 Exh. "I"). The inference of Dr. Levine's continued successful presence in the market and continued access to hospital facilities is that no patient was deprived of the opportunity to choose Dr. Levine as his or her physician for internal medicine services.

Although the review of the factual record in this case is arguably outside the scope of this Court's review on a petition for writ of certiorari, these Respondents felt that it was necessary to provide some of the relevant facts which were reviewed by the courts below in arriving at their decisions.

Dr. Levine also misstated several material facts in this matter. Specifically, Dr. Levine has attempted to portray CFMA as the alter ego of Healthchoice. These Respondents would suggest that the factual findings of the Eleventh Circuit Court of Appeals, set forth in its Opinion dated January 23, 1996, accurately depict the relationship of the parties and the relevant facts in this matter. Nevertheless, these Respondents feel compelled

to correct specific misstatements of fact made by Dr. Levine in his Petition:

1. Dr. Levine states that CFMA requires adherence by its members to the Master Payor Rate Schedule as a condition of membership in CFMA. However, the Master Payor Rate Schedule is developed by the non-physician board members of Healthchoice for the purpose of providing a means of compensation to be negotiated with third-party payors. CFMA has absolutely no input or direction in determining the amounts set forth in the Master Payor Rate Schedule and individual member physicians are free to opt out of any contract if they are unhappy with the fees. Moreover, the Master Payor Rate Schedule simply establishes the maximum amount that Healthchoice-contracted payors are required to pay physicians for services rendered to that payor's covered persons. Physicians are paid the lesser of their usual and customary charges or the amount calculated from the Master Payor Rate Schedule.

2. Dr. Levine also states that there are "68,000 CFMA patients". Dr. Levine is clearly aware that, at all times relevant to this action, there were approximately 68,000 Healthchoice enrollees. There are no "CFMA patients".

3. Dr. Levine asserts that CFMA promulgated the Rule of Necessity "by which physician participation in CFMA was closed to new applications unless an internally determined need existed for certain specialties" (*Levine Petition*, p. 3). The Rule of Necessity, as it currently exists and as it existed at all times relevant to this action, was promulgated by

Healthchoice as a means to provide the proper number of physicians in various subspecialties to cover the geographical territories served by the Healthchoice Preferred Provider Organization. The Rule of Necessity is administered by the staff of Healthchoice without input from CFMA members or other physician providers (R3-82-¶ 8).

4. Dr. Levine states that CFMA membership is closed to assure each CFMA doctor a sufficient number of patients to equal 15 to 20% of his respective practice and that CFMA members are required to do in-hospital rather than outpatient procedures. It has been well established that the Healthchoice provider panel is closed for the sole reason of providing provider physicians with the prospect of increased numbers of patients. In return, the physicians agree to accept set fees for their services and agree to submit themselves to rigorous quality control and utilization review by Healthchoice. The closed panel is required by many third-party payors.

5. Dr. Levine states that the Boards of Directors of CFMA and Healthchoice are "interlocking" (*Levine Petition*, p.6). The Board of Directors of Healthchoice is comprised of eight individuals, four of whom are physicians appointed by CFMA. The remaining four members are unrelated to CFMA. The Board of Directors of CFMA may or may not be limited to Healthchoice physicians and is not comprised at all of any members of the administration or staff of Healthchoice.

The statements described above are contrary to the facts that have been revealed in the this case. The U.S.

District Court and the Eleventh Circuit Court of Appeals, upon reviewing the actual factual record in this case, determined that Dr. Levine's antitrust claims were meritless. These Respondents respectfully suggest that this Court follow the factual findings set forth in the Eleventh Circuit opinion.[1]

II.

ARGUMENT AND CITATION OF AUTHORITY

A. Dr. Levine Has Not Shown Any Grounds For This Court To Grant His Petition For Writ Of Certiorari In This Matter.

Supreme Court Rule 10 provides that review on a Writ of Certiorari is a matter of judicial discretion. The Rule goes on to provide, in relevant part, that the factors to be considered by the Court in granting certiorari include the following:

> (a) the United States Court of Appeals has entered a decision in conflict with the decision of another United States Court of Appeals on the same important matter; . . . or has so far departed from the accepted and usual course of judicial proceedings, . . . as to call for an exercise of this Court's supervisory power;
>
> (c) . . . a United States Court of Appeals has decided an important question of federal law that has not been, but should be, settled by this

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[1] Because this case went to the Eleventh Circuit on Appeal of Summary Judgment, it was required to construe the facts in the light most favorable to Dr. Levine. *Forbus v. Sears Roebuck & Company*, 30 F.3d 1402, (11th Cir. 1994), *cert. denied*, 115 S.Ct. 906 (1995).

> Court, or has decided an important federal question in a way that conflicts with relevant decisions of this Court (*Supreme Court Rule 10*).

The principal purpose for which the U.S. Supreme Court uses certiorari jurisdiction is to resolve conflicts among circuit courts of appeals concerning the meaning of a provision of federal law. *Braxton v. United States*, 500 U.S. 344, 111 S.Ct. 1854 (1991).

Dr. Levine has alleged that this Court should exercise its certiorari jurisdiction in this matter to clarify three conflicting standards for analyzing claims under Section 1 of the Sherman Act.[2] Dr. Levine also asserts that the Eleventh Circuit's failure to find a per se violation in this case violates prior Supreme Court precedent, thus justifying the grant of his Petition. However, as shown by its opinion and as more fully discussed below, the Eleventh Circuit reviewed each of the existing standards in reviewing Dr. Levine's Section 1 claims, and properly determined that his claims failed under the Rule of Reason. The Eleventh Circuit's decision was supported by prior decisions of this Court and by numerous other relevant Circuit Court decisions.

The Court's decision is also supported by public policy. This case involves a very successful physician who is aggrieved because he was denied admission to a particular managed care plan. Dr. Levine's only interest in becoming a Healthchoice provider was to increase his personal income. For example, he has never been interested in challenging the methods by which provider fees

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[2] 15 U.S.C. § 1

are set by Healthchoice, and, although he may argue to the contrary, has never been interested in changing the way that providers are admitted to the network. The Petitioner simply wants to become part of the network because he has heard it "pays well" (R2-54-65). There has been absolutely no evidence presented of any harm or the potential for future harm to competition in this matter. To the contrary, the uncontradicted evidence shows that no patient has been deprived of the use of the Petitioner's services and that Petitioner's medical practice thrived despite his exclusion from the Healthchoice provider panel *and* the temporary suspension of his medical staff privileges at ORHS. The facts of this case, including the competitive status of the relevant markets and the phenomenal success of the Petitioner's medical practice, make it a particularly poor vehicle to be used to review existing antitrust law. Therefore, this court should not accept certiorari jurisdiction in this matter and Dr. Levine's Petition should be denied.

B. There Is No Conflict Among This Court's Decisions Reviewing Alleged Sherman Act Violations Which Justifies The Exercise Of This Court's Certiorari Jurisdiction In This Matter.

Dr. Levine alleges in his Petition that this Court has allowed three conflicting legal standards for boycotts to "uneasily co-exist" (*Levine Petition*, p.11). Although the precise application of the Court's standards of review of antitrust cases is often not easily applied, the standards have developed over time in response to complicated fact patterns which demand sophisticated analysis. However, the facts of this case do *not* demand such analysis and do

not lend themselves to a meaningful review of the three legal standards.

This Court has historically provided that alleged combinations in violation of the Sherman Act should be reviewed as either per se violations or under the Rule of Reason. Per se violations have been found in situations where the defendants' actions are so plainly harmful to competition and so obviously lacking in any redeeming pro-competitive values that any alleged restraint is presumptively unreasonable. *Broadcast Music, Inc. v. CBS*, 441 U.S. 1, 8 (1979). The types of cases deemed per se violations are very limited. Such cases have generally been limited to those in which firms with market power boycott suppliers or customers in order to discourage them from doing business with a competitor. *F.T.C v. Indiana Federation of Dentists*, 476 U.S. 447, 458 (1986). In the vast majority of cases, the courts apply the Rule of Reason. In order to establish an antitrust violation under the Rule of Reason, the plaintiff must establish that the defendants have market power in the relevant product and geographic markets; and that the challenged combination or agreement constitutes an unreasonable restraint on competition. *Standard Oil Co. v. United States*, 221 U.S. 1 (1911).

A third standard of analysis was created by this Court in 1986 in its decision in the case of *F.T.C. v. Indiana Federation of Dentists, supra.* In *Indiana Federation of Dentists,* this Court, while specifically declining to classify the defendant's actions as a per se violation, held that the need to establish market power could be obviated where there was proof of "actual detrimental effects" on competition. *Id.* at 460-461. The Court held that the withholding

of dental x-rays from insurance companies by a majority of dentists in particular areas, thus eliminating price competition among the dentists, resulted in "actual, sustained adverse effects on competition . . . sufficient to support a finding that the challenged restraint was unreasonable even in the absence of elaborate market analysis". *Id.* at 461. It is within the framework of these three standards that modern antitrust cases are analyzed by the courts.

C. The Eleventh Circuit Court of Appeals Properly Decided That Dr. Levine's Antitrust Claims Were Meritless Under The Rule of Reason.

Under the Rule of Reason, the court must evaluate the alleged activity by analyzing the facts peculiar to the business, the history of the alleged restraint, and the reason it was imposed, so that it can evaluate the competitive significance of the activity complained of. *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978). The activity only violates Section 1 if it is adjudged an unreasonable restraint on competition. *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284 (1985). In *Northwest Stationers*, the plaintiff was expelled from membership in a lucrative cooperative buying agency after a relatively minor breach of the agency's bylaws. Plaintiff argued that its expulsion, without notice or an opportunity for a hearing, constituted a group boycott that should be deemed a per se violation of Section 1. The Supreme Court disagreed, stating that "Rule of Reason analysis guides the inquiry unless the challenged action falls into the category of agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue

are conclusively presumed to be unreasonable . . . " *Id.* at 289; quoting, *Northern Pacific R. Co. v. United States*, 356 U.S. 1 (1958). Such cases are deemed per se unlawful. In *Northwest Stationers*, the court found that wholesale purchasing cooperatives were not an activity likely to have a predominantly anticompetitive effect, and applied the Rule of Reason, not per se, analysis. *Id.* at 295-298. Per se treatment of certain antitrust activity has been justified by this Court to avoid the burdensome inquiry into actual market conditions in situations where the likelihood of harm to competition arising from the activity is so great that the costs of such inquiry cannot be justified. *Jefferson Parish Hospital District 2 v. Hyde*, 466 U.S. 2 (1984).

Cases in which the Supreme Court has applied the per se analysis have generally involved joint efforts by a firm or firms to cut off access to a "supply, facility or market necessary for the boycotted firm to compete . . . ". *Northwest Stationers, supra* at 294. Therefore, in order to invoke the per se rule, the plaintiff must present a threshold case that the challenged activity fits into a category likely to have predominantly anticompetitive effects. *Id.* at 298. The types of cases to which per se analysis should be applied should not be expanded indiscriminately. *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. at 458.

(i) Group Boycott Claims Against Healthchoice and CFMA.

Following this Court's direction from the cases cited above, the Eleventh Circuit Court of Appeals properly applied the Rule of Reason to the Petitioner's antitrust claims against Healthchoice and CFMA. As shown by the

uncontroverted facts set forth above, the managed care market in the Orlando Area is very competitive. Healthchoice, with only 6% of the relevant market, has no ability to adversely effect competition. Each payor which contracts with Healthchoice is free to terminate its contract upon relatively short notice and negotiate agreements with other managed care plans. No Healthchoice physician is precluded from joining the provider panels of other managed care networks and, in fact, most physicians are members of several networks. As a result, it is virtually impossible for Healthchoice to restrict competition among other managed care plans. Finally, no patient who is not a Healthchoice member is precluded from using a Healthchoice physician. Even assuming arguendo that Healthchoice had conspired with CFMA or its member physicians to exclude Dr. Levine from the network, the Eleventh Circuit found that such action had no effect on competition in the market for internal medicine physician services. *Levine v. Central Florida Medical Affiliates, Inc., et al.*, 72 F.3d 1538, 1553 (11th Cir. 1996).

On the other hand, there are many pro-competitive reasons why Healthchoice would seek to restrict membership in its preferred provider network. By limiting the number of panel physicians, Healthchoice can assure that its providers get greater access to more patients. In return, the physicians are willing to accept lower fees for their services and submit themselves to quality assurance and utilization management review. By limiting the number of physician providers, Healthchoice is able to provide a quality product at a lower cost. This allows Healthchoice to compete more effectively with the 38

other PPOs, 11 other HMOs, and numerous TCIC companies in the Orlando Area. Significantly, Healthchoice submitted to the District Court in support of summary judgment an Affidavit by the health benefits manager of Healthchoice's largest managed care customer (Orange County Public Schools) in which this customer confirmed that it desired Healthchoice to operate a closed panel of physicians (R3-76-¶¶ 6, 7).

Cases relating to the exclusion of a particular provider from a managed care plan have been decided by other courts under the Rule of Reason. In *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Association, Inc.*, 996 F.2d 537 (2d Cir. 1992), a private radiology group of doctors was denied membership in an independent association of private physicians who were providing medical care through an HMO. The stated basis for the denial was that the radiology group was located outside the plan's designated service area. *Id.* at 540. As a result, the radiologists filed Sherman Act Section 1 and 2 claims against the independent physicians association and the HMO. The Second Circuit Court of Appeals affirmed the District Court's grant of summary judgment in favor of the defendants on the grounds that the plaintiff had not established an unreasonable restraint of trade under the Rule of Reason. The Court in *Capital Imaging* acknowledged the "Supreme Court's caution about extension of the per se doctrine into new areas, see *Indiana Fed'n of Dentists*, 476 U.S. at 458-59, [as well as] the recognized procompetitive virtues of . . . HMOs." *Id.* at 545. It also found that the defendants' actions had no actual detrimental effects because there was no evidence of an increase in prices or a deterioration of the quality of radiological

services to the plan's enrollees. *Id.* at 546. As a result, the court applied the Rule of Reason and found that the defendants were unable to injure competition because of their small market share. The same analysis holds true in this case.

Petitioner has cited no factually similar cases which support his claim that this case should be analyzed as either a per se violation of the Sherman Act or pursuant to the hybrid analysis set forth in *F.T.C. v. Indiana Federation of Dentists, supra*. Rather, Dr. Levine cites cases outside of the managed health care arena in an effort to classify the Healthchoice PPO as a per se illegal group boycott. However, cases such as *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959), and *F.T.C. v. Superior Court Trial Lawyers Association*, 493 U.S. 411 (1990), upon which Petitioner heavily relies, are inapplicable to the facts in this case.

In *Klor's*, a large chain of retail department stores conspired with various manufacturers and distributors to prevent sales of electronics to the plaintiff. The complaint alleged that the combination effectively prevented Klor's from buying appliances in a competitive market and drove it out of business as a dealer in the defendant's products. *Klor's*, 359 U.S. at 213. The Court, in its opinion, clearly distinguished the facts in *Klor's* from the facts in this case when it stated that "[t]his is not a case of a single trader refusing to deal with another . . . " *Id.* at 212. Instead of a "wide combination" conspiring against a competitor, this case involves a single preferred provider organization which, through its administrative procedures, denied membership to a single physician. There

was no collaborative action and there was no harm to the physician's ability to compete in the relevant market.

In *Superior Court Trial Lawyers,* the boycott by a majority of lawyers providing indigent criminal defense services in the Washington, D.C. area had the effect of crippling an already over-burdened court system. *F.T.C. v. Superior Court Trial Lawyers Association, supra* at 417, 418. Again, there was an agreement among competitors which resulted in a substantial restraint on competition in the relevant market. The undisputed facts in this case clearly establish that Healthchoice does not compete in any market with Petitioner and that its actions in limiting its provider panel had no effect on competition.

None of the defendants in the above-cited cases offered any pro-competitive reasons for their actions. Conversely, Healthchoice presented uncontroverted evidence that its closed provider panel is demanded by its customers as a means of containing health care costs. Moreover, the Rule of Necessity, by which new physicians are admitted to the provider panel, is administered by non-physician staff members of Healthchoice without the input from its member physicians or the physician members of CFMA. Healthchoice provides a product – a package of medical services – that is marketed to third party payors in competition with other PPOs, HMOs and TCIC companies. It does not compete with the Petitioner. The complete lack of evidence of any anti-competitive effect and the pro-competitive reasons for the Rule of Necessity distinguish this case from those cited above. As a result, Dr. Levine's reliance on the "group boycott" cases is misplaced.

As recognized by the Department of Justice, the managed care market is relatively new to the healthcare industry. In its enforcement policies relating to multi-provider networks, the Department of Justice has noted that "where a geographic market can support several multi-provider networks, there are not likely to be significant competitive problems associated with the exclusion of particular providers by particular networks." *Levine*, 72 F.3d at 1550; citing DOJ Enforcement Policy, *available in* 1994 WL 642477 at *42 (F.T.C.). As previously stated, there were approximately 38 preferred provider organizations and 11 health maintenance organizations in the Orlando Area. These organizations had a combined coverage of approximately 69% of the population. The remainder of the population is covered by numerous traditional comprehensive insurance coverage companies in the area or have no coverage at all. Healthchoice had approximately sixty eight thousand enrollees or approximately a 6% share of the Orlando health care market. Accordingly, the Eleventh Circuit properly found as a matter of law that there was no significant anticompetitive effect resulting from the exclusion of Dr. Levine from this particular network.

(ii) Price-Fixing Claim Against Healthchoice and CFMA.

Dr. Levine has raised a new argument in his Petition. Specifically, he now asserts that the establishment of the Master Payor Rate Schedule by Healthchoice is a type of price-fixing which should be deemed per se unlawful. In reviewing the Complaint, it is interesting to note that the Petitioner did not raise any allegations of price fixing.

Specifically, Count I of his Complaint is simply titled "Conspiracy to Unreasonably Reduce the Availability of and Competition in Services to Consumers of Medical Services" (R1-1-5). In his portion of the Pre-trial Statement prepared by the parties on the eve of trial, Petitioner defined the concise issues to be tried relating to Count I of his Complaint as:

> "Did the Defendant's contract, combine or conspire with one another and/or among the doctor members at CFMA to exclude Plaintiff from being a provider under CFMA and/or Healthchoice?"; and
>
> "Did the Defendant create a health care plan (PPO) that locked in consumers and excluded physicians like Plaintiff?" (R3-132-23).

Price-fixing was not even an issue to be litigated at the trial. In fact, throughout this litigation, the Petitioner's complaint has been that he was excluded as a member of the Healthchoice PPO. He wanted to become a member of the Healthchoice PPO because he heard it paid well and he thought it would improve his practice (R2-52-438, 439); (R2-54-65). He wanted to become a part of the plan not challenge the method by which fees are set. As a result, the Eleventh Circuit properly found that there was "no genuine issue of material fact regarding the existence of an agreement to fix prices . . . ". *Levine*, 72 F.3d at 1549.

Dr. Levine compares this case with this Court's decision in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982). In *Maricopa*, a group of doctors representing approximately 70% of the practitioners in the area formed an association for the purpose of establishing a schedule of maximum fees that participating doctors

would accept as payment in full for services performed for patients insured under approved plans. *Id.* at 339. The *physicians themselves* agreed by majority vote on the maximum fee that they would claim as payment in full for their services. *Id.* at 335-336. The Court acknowledged that fee schedules may be desirable in certain circumstances, but appeared troubled by the fact that the fees were set by the physicians themselves. *Id.* at 352. As a result, a closely divided Court found that the arrangement in question was a form of illegal price-fixing. *Id.* at 357.

In the present case, it is the non-physician members of the Board of Directors of Healthchoice that establish the rates and conversion factors which are used to make up the Master Payor Rate Schedule. The physician members of the Board of Directors of Healthchoice are required to remove themselves from any discussions regarding the establishment of rates for physician services. The rates are then negotiated by Healthchoice individually with prospective payors and the agreed upon rate schedule is presented, in toto, to the provider panel. Any doctor is free to opt out of any contract under which he is unhappy with the amount of the fee to be received. The provider is also free to accept an amount less than the proscribed maximum fee or to waive any copayment which may be due from an out-of-network provider. Any physician is also free to join other managed care networks if the fees are more favorable or for any other reason. Therefore, this case can be easily distinguished from *Maricopa County* as the maximum fees for individual physician services are determined by an independent entity seeking to market its package of physician services to

third-party payors such as large businesses and local governments.

The Eleventh Circuit acknowledged that the Petitioner did not argue in the court below that the Respondents had illegally fixed prices. However, the Eleventh Circuit also noted that portions of Petitioner's brief assumed the existence of such an agreement and addressed, in dictum, Petitioner's alleged price-fixing claims. The court found that the Healthchoice PPO involved "an agent or third party conveying to purchasers information obtained individually from providers in the network about prices the network participants are willing to accept, and conveying to providers any contract offers made by purchasers." *Levine*, at 1549. As a result, the method by which Healthchoice negotiates the fees to be paid to its providers was not prohibited by the Sherman Act.

Although some managed care plans have come under scrutiny lately, those cases have involved *jointly owned* physician-hospital organizations with extremely large market shares which allegedly restrained competition among the physicians and impeded the entry of other managed care plans into the relevant markets. In *United States v. Health Choice of Northwest Missouri, Inc.*, No. 95-6171-CV-5J-6 (W.D.Mo.), reprinted in, 60 Fed.Reg. 51,808 (Oct. 4, 1995) and *United States v. HealthCare Partners, Inc.*, No. 395-CV-01946-RNC (D.Conn.), reprinted in, 60 Fed.Reg. 52,014 (Oct. 4, 1995), the Department of Justice alleged physician participation in the relevant markets of 85% and 98%, respectively. In addition, the relevant hospitals in both cases were the only acute care

hospitals in their respective markets. There was also evidence that the physicians refused to deal with any managed care plans except through their organization and that the organizations were restricting access to the physicians. Therefore, the Department of Justice felt that the structure of the organizations in question had the potential to restrict price competition among the physicians and limit the development of managed care plans.

In the present case, Healthchoice is not owned by the physician providers. The PPO has a very small market share in a highly competitive market. In addition, all of the agreements with its providers allow the physicians to participate in other competing managed care plans. Even the President of Healthchoice participates in several other competing managed care plans (R3-83-¶ 4). Healthchoice is unable to restrict access to its physician providers or limit price competition because any effort to unilaterally raise prices above market levels would result in payors (and physicians) switching to one of the other managed care plans in the area. This case is clearly distinguishable from those that have been challenged by the government. More importantly, an action brought by a single physician challenging his exclusion from a managed care network is not an appropriate vehicle for review of managed health care by this Court.

(iii) Group Boycott Claims Against ORHS.

Dr. Levine also argues that the temporary suspension of his medical staff privileges by ORHS should have been deemed per se illegal. He ignores the fact that the peer review process is a requirement for licensing under state

law. He also ignores the fact that he at all times maintained (and utilized) active staff privileges at other hospital facilities in the Orlando area, including the largest hospital network in the area. Most importantly, Dr. Levine is asking this Court to ignore the benefits to patient care which are attributable to the physician peer review process. The benefits of having a physician's work reviewed by other doctors having knowledge in the medical field is beyond dispute. Physician peer review is not an activity which can be said to have such obvious anti-competitive effects as to justify classification as a per se violation of the Sherman Act. Dr. Levine's argument is merely an attempt to re-litigate his disciplinary proceeding in a federal treble damages forum.[3] Such a result is not within the spirit and intent of the federal antitrust laws.

Numerous decisions have addressed the issues of medical staff disciplinary actions under the Rule of Reason. See, e.g., *Oksanen v. Page Memorial Hospital*, 945 F.2d 696 (4th Cir. 1991), *cert. denied*, 112 S.Ct. 1972 (1992); *Bolt v. Halifax Medical Center*, 891 F.2d 810 (11th Cir. 1990), *cert. denied*, 495 U.S. 924 (1990); and *Lie v. St. Joseph Hospital of Mt. Clemmons, Michigan*, 964 F.2d 567 (6th Cir. 1992). In fact, these respondents are unaware of a single case in which a medical staff disciplinary action has been deemed a per se violation of the Sherman Act. As acknowledged by counsel for Dr. Levine at oral argument at the Eleventh Circuit, the proper standard for antitrust

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[3] Dr. Levine also filed a companion case asserting state law claims against ORHS which remains pending. (Orange County, Florida Circuit Court Case No. CI93-1478).

claims arising from medical staff disciplinary actions is the Rule of Reason. *Levine,* 72 F.3d at 1553. A contrary holding would federalize the state-mandated peer review process and provide a treble damages forum for any disgruntled physician who was aggrieved by the process.

In *Oksanen v. Page Memorial Hospital, supra,* the plaintiff's medical staff privileges were revoked by the medical staff at the defendant hospital based on allegations of numerous incidents of disruptive behavior at the hospital. In response, Dr. Oksanen sued the hospital and members of the medical staff alleging Sherman Act Section 1 and 2 violations and other state law violations. The court found that Dr. Oksanen's efforts to show an unreasonable restraint on trade were not satisfied by showing only that he had suffered an economic injury. *Oksanen, supra,* at 708. As stated by the Court:

> If the law were otherwise, many a physicians' workplace grievance with a hospital would be elevated to the status of an antitrust action. To keep the antitrust laws from becoming so trivialized, the reasonableness of a restraint is evaluated based on its impact on competition as a whole within the relevant market. *Id.* at 708; *Atlantic Richfield Co. v. USA Petroleum Co.,* 495 U.S. 328 (1990).

Therefore, while the court recognized that Dr. Oksanen's individual practice may have been hurt by the hospital's actions, there was no evidence that competition had been harmed in the relevant market. *Id.* at 709. As a result, Dr. Oksanen's Section 1 claim failed.

The modified Rule of Reason analysis propounded by the court in *Indiana Federation of Dentists* is also inapplicable to a peer review case. *Lie v. St. Joseph Hospital of Mount Clemmons, Michigan, supra.* In *Lie,* the plaintiff's surgical privileges were suspended after an extended review indicated that the patient care he had rendered was unacceptable. As a result, Dr. Lie sued the hospital and certain individual physicians for antitrust violations (specifically, Sherman Act Section 1). Although he attempted to define the relevant market, Dr. Lie argued that he did not have to establish that the defendant hospital had market power under the authority of *F.T.C. v. Indiana Federation of Dentists,* 476 U.S. 447 (1986) (the presence of a "naked restriction on price or output" does not require an inquiry into market power. *Id.* at 460). However, the Sixth Circuit Court of Appeals rejected this argument. Instead, the Court recognized that the peer review process has a public purpose of policing the competence of physicians and can enhance competition. *Lie,* at 570. Therefore, the plaintiff was required to allege and prove market power and an unreasonable restraint on competition. The only evidence produced by Dr. Lie was a reduction in his own income and an affidavit from an expert that the peer review process could chill competition among physicians. The court found that evidence insufficient to establish an unreasonable restraint on trade, especially in view of the defendant's evidence of an increase in the number of surgeons practicing in the area. *Id.* at 570.

Dr. Levine continues to rely on Justice Scalia's dissent in *Summit Health, Ltd. v. Pinhas,* 111 S.Ct. 1842 (1991). This Court reviewed the *Summit Health* decision solely to determine whether the complaint in that case satisfied the

interstate commerce requirement of antitrust jurisdiction. *Id.*, at 1844. Justice Scalia, while dissenting from the majority's holding that the jurisdictional requirement was satisfied, also expressed his displeasure at the prospect of "federalizing" physician disciplinary actions. Specifically, Justice Scalia wrote that it was a mistake to treat claims over the denial of hospital privileges as federal antitrust claims because the federal courts should not be trivialized by the handling of routine business disputes. *Id.*, at 1854. These Respondents agree with this analysis.

The decision of the Eleventh Circuit to analyze the Petitioner's antitrust claims against ORHS under the Rule of Reason was consistent with decisions from other Circuits which have faced similar situations. All have required that the Plaintiff satisfy the Rule of Reason to pursue an antitrust claim relating to a physician disciplinary procedure because the pro-competitive and other societal benefits of physician peer review far outweigh any alleged anticompetitive effects. The Petitioner has never made any effort to attempt to identify or define the relevant product and geographic markets relating to his Section 1 claims against ORHS. Instead, he relied on a per se analysis or the *Indiana Federation of Dentists* hybrid analysis. The only evidence relating to market definition in this case was provided by the Respondents. The Eleventh Circuit gave the Petitioner every benefit of the doubt while analyzing his antitrust claims against ORHS under the Rule of Reason. The overwhelming result of such analysis was that the Petitioner had failed to prove that the disciplinary action in this matter had any effect on competition in the relevant markets. *Levine*, 72 F.3d at 1554. The Eleventh Circuit properly applied the Rule of

Reason in affirming the summary judgment granted against Dr. Levine on his antitrust claims against ORHS in this matter and certiorari should not be granted to review its decision.

(iv) "GVR"

These Respondents join in that portion of the Response Brief filed by CFMA relating to the reasons why "GVR" is inappropriate in this matter.

III.

CONCLUSION

The most cogent arguments for the denial of Dr. Levine's Petition can be found in the Eleventh Circuit's Opinion. The judges obviously reviewed the matter thoroughly and provided an insightful analysis of the relevant antitrust precedents. There is no reason for this Court to review the Eleventh Circuit's decision in this case. The decision below was substantively correct and was not a product of any "confusion" in the law.

In addition, given the increasing importance of managed care and the requisite development of provider networks involved in managed care, it would be a serious mistake to open the doors of the federal courts as a forum for review of network decisions made by the many managed care plans operating and being developed across the country. The formation of such networks, which is being demanded by market forces, necessarily means that some providers will be in a network and some will be

excluded. If Dr. Levine's position is accepted, every provider who is excluded from a particular network would be a potential federal court antitrust plaintiff. The appealing lure of treble damages would only serve to increase the potential that such claims would be filed.

Where there is *no* evidence of any detrimental effect on competition, as the courts below in this case have noted, it would be an extreme departure from prior law to allow a federal antitrust action to proceed. The acceptance by the Supreme Court of the argument that provider exclusions from managed care plans are per se antitrust violations would completely federalize the law in this area and would insert the federal courts into the market relationships between willing buyers and sellers in a highly detrimental fashion. Therefore, for the reasons set forth above, Orlando Regional Healthcare System, Inc., Sand Lake Hospital, and Healthchoice, Inc. hereby respectfully request that Dr. Levine's Petition for Writ of Certiorari be denied.

Respectfully submitted,

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